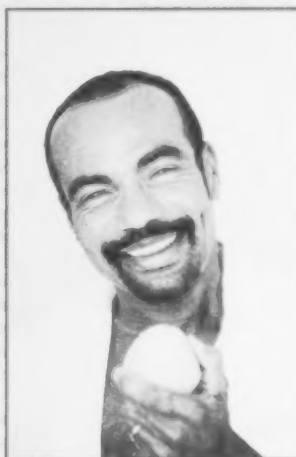


NOVEMBER 2004

2nd Edition

HEALTH Performance Indicators

*A Report to New Brunswickers
on Comparable Health and Health System Indicators*



New  Nouveau
Brunswick
C A N A D A
Health and Wellness

HEALTH Performance Indicators

A Report to New Brunswickers on

Comparable Health And Health System Indicators

November 2004

2nd
Edition

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FOREWORD

In September, 2002 New Brunswick released its first *HEALTH Performance Indicators* report. That report was produced in accordance with the 2000 First Ministers' Communiqué on Health which gave direction to Health Ministers to collaborate on the development of a comprehensive framework using jointly agreed upon comparable indicators to report to Canadians on health status, health outcomes and the quality of health services.

The February 2003 First Ministers' Accord on Health Care Renewal (The Accord), directed Health Ministers to further develop the comparable indicator reporting process initiated in 2002. As a result, New Brunswick along with the federal government and the other provincial and territorial jurisdictions has undertaken a second round of performance indicator development and reporting. The second edition of the *HEALTH Performance Indicators* report reflects the results of this second round of performance indicator refinement and development.

This report fulfills the Province of New Brunswick's commitment to report regularly to the people of New Brunswick on the state of our health and the performance of our health care system. This report has been subject to a number of specified auditing procedures carried out by the Auditor General of New Brunswick, at the request of the Minister of Finance (See Auditor General's Report on the Results of Applying Specified Auditing Procedures).

Management's Responsibility

The New Brunswick Department of Health and Wellness is responsible for the presentation of the information contained in the *HEALTH Performance Indicators* report. This responsibility includes the analysis, presentation and interpretation of the data within the parameters defined by the federal/provincial/territorial Performance Reporting Technical Working Group (PRTWG) and approved by the Conference of Deputy Ministers of Health and / or the Co-Chairs of the Advisory Committee on Governance and Accountability.

In preparing this report, the Deputy Minister and management of the Department of Health and Wellness have relied on information provided by external organizations, including Statistics Canada, the Canadian Institute for Health Information (CIHI), and Health Canada. While we have relied on this information, we are also aware that health indicators data needs to be improved. This report is consistent with all significant requirements for reporting on comparable health indicators, as defined in The Plan for Reporting Comparable Health Indicators in November 2004 (the Plan), approved by the Conference of Deputy Ministers of Health, pursuant to the February 5, 2003 First Ministers' Accord on Health Care Renewal. Any significant departures from the Plan are noted in the report.

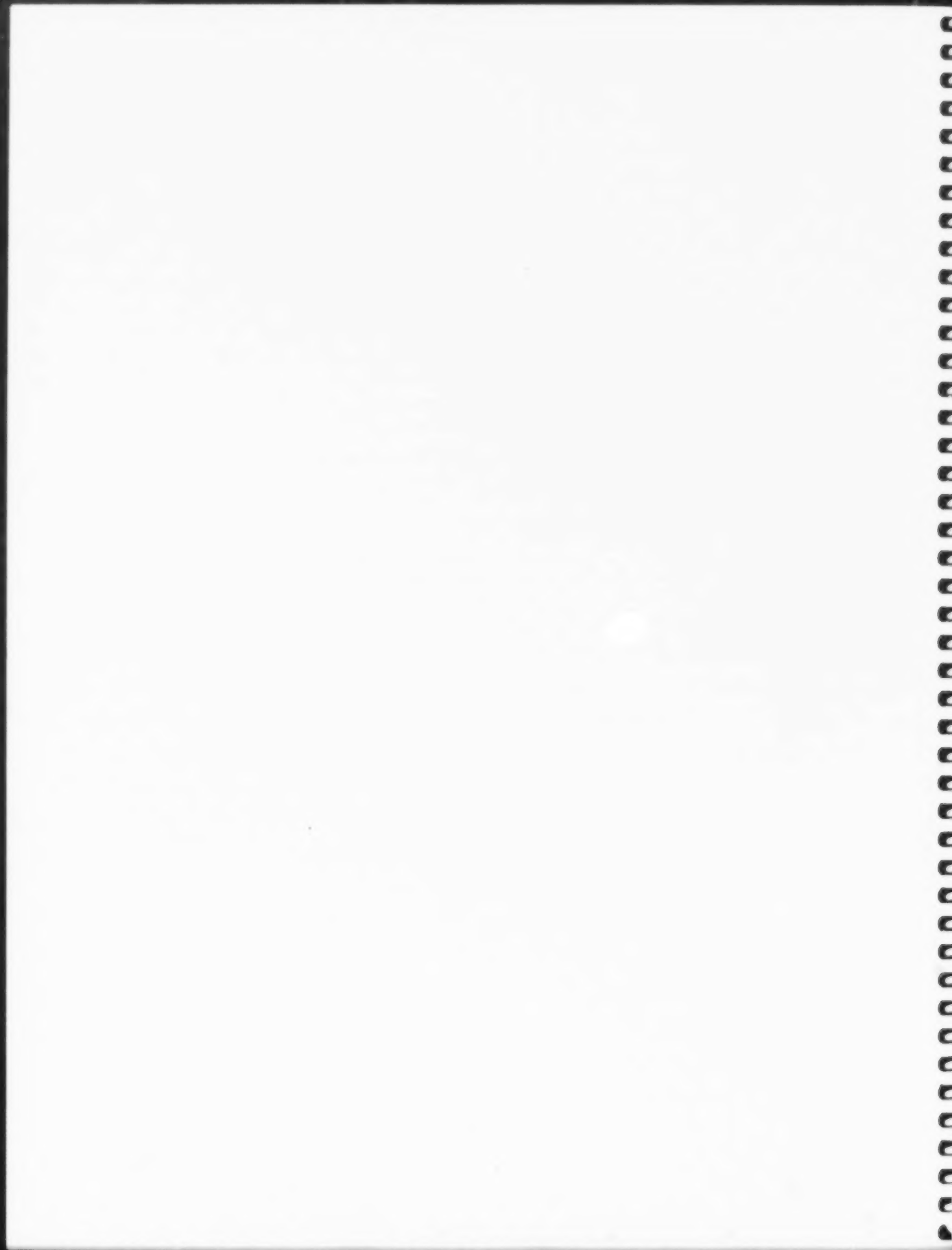
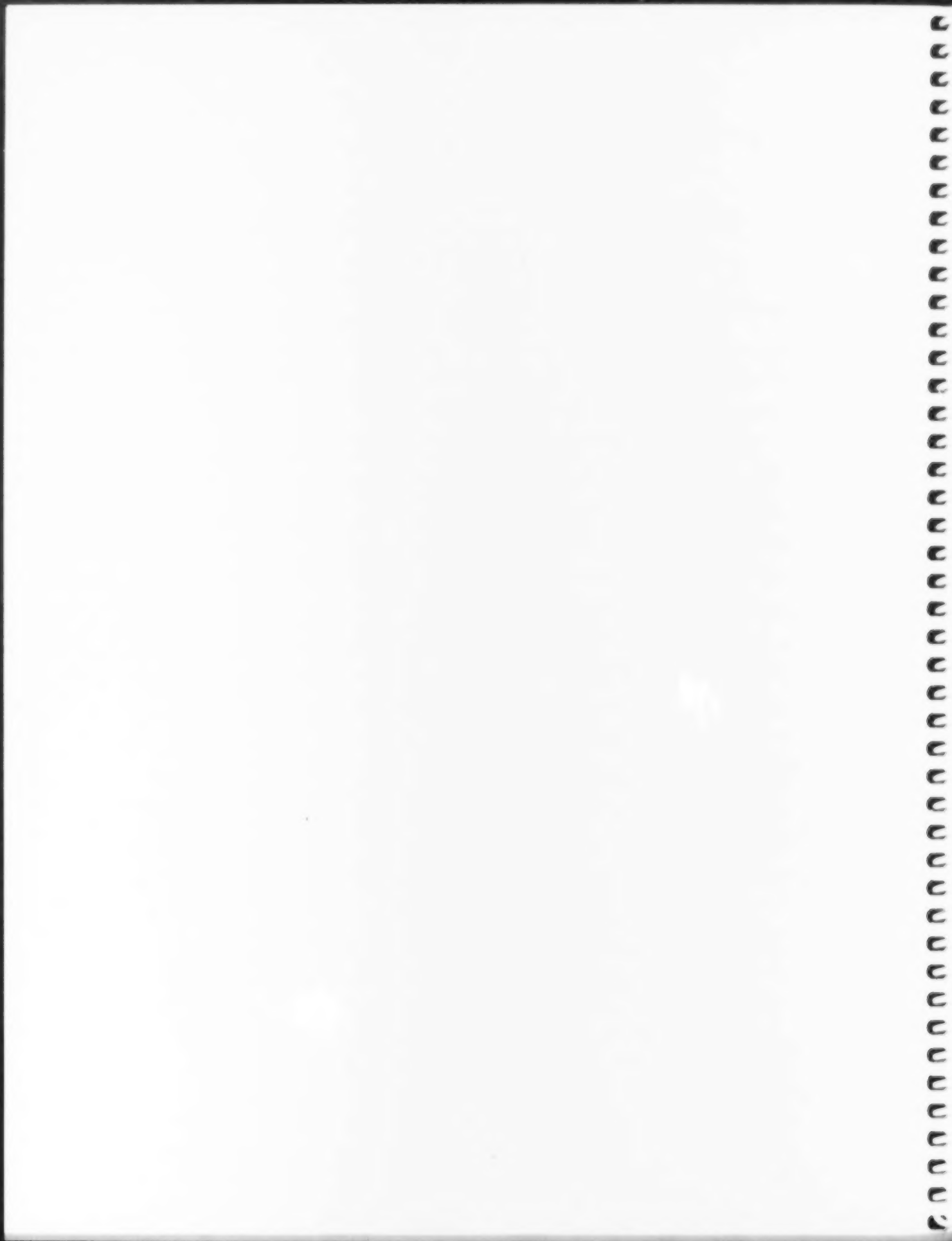


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INTRODUCTION

The 2004 edition of the *HEALTH Performance Indicators* report is the second in a planned series of reports designed to provide the people of New Brunswick with objective, reliable and consistent information about our health status and the performance of our health care system. The *HEALTH Performance Indicators* reports are one of several means by which the Department of Health and Wellness (DHW) keeps New Brunswickers informed about the health status of our population and the effectiveness of our health care system. In particular, this series of reports is designed to complement and to be used in conjunction with the New Brunswick Health Report Card, which was first released in 2003.

A unique feature of the *HEALTH Performance Indicators* report is that it is part of a nation-wide effort to provide citizens with health status and health system performance information that is comparable across all Federal, Provincial and Territorial (FPT) jurisdictions. Over the past four years, the Department of Health and Wellness has collaborated with all FPT jurisdictions to develop a common process for reporting on a wide variety of measures related to access to health care services, the quality of those services, and the health and wellness of the general population. Each FPT jurisdiction has agreed to analyze and present their results in a format that is meaningful to their public and that is comparable across jurisdictions. To enhance access to this information and encourage inter-jurisdictional comparisons each FPT jurisdiction will release a document similar to New Brunswick's *HEALTH Performance Indicators* report in November 2004.

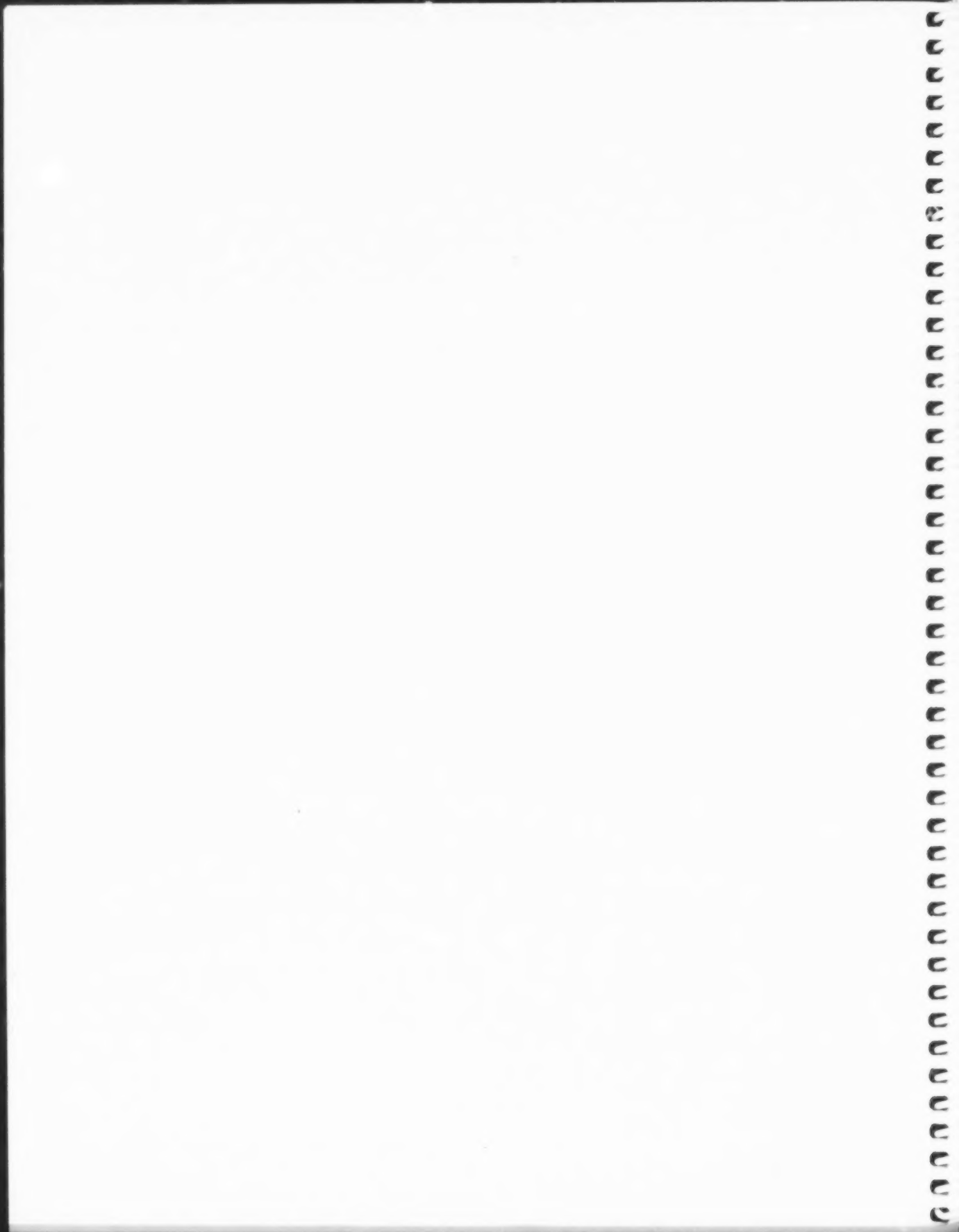
The second edition of the *HEALTH Performance Indicators* report differs substantially from its predecessor in terms of the number of indicators reported and discussed. While the 2002 report included information on fifty-five separate indicators, the 2004 report deals with only seventeen indicators. As discussed below, information on a much larger number of indicators has been produced for comparable reporting in 2004. However, based on expert advice and public feedback, the PRTWG has recommended that jurisdictions focus on a small set of 'core' indicators when reporting to their general public. This core set of indicators attempts to address key areas of public interest and provide high level measures of population health and health system performance.

This edition of the *Health Performance Indicators* report is designed for 'stand-alone' use. A number of the indicators in this edition are new and readers will find no corresponding indicators in the 2002 edition. Where feasible, available historical data for each of the core indicators has been included in this edition - readers should not have to go to the 2002 edition to find historical data. In fact, readers are cautioned that comparing results from the 2002 edition with the 2004 edition could lead to erroneous conclusions.

Purpose

Measuring, tracking and reporting to citizens on comparable health indicators supports efforts to strengthen and renew New Brunswick's publicly funded health care system in a number of ways:

- It allows us to see how we are doing in attaining our goals and objectives;
- It assists those responsible for health care delivery to make more informed choices;
- It promotes the identification and sharing of best practices, contributing to service innovations;
- It helps us understand how publicly funded health services are being delivered; and
- It encourages us to take a more active role in improving and maintaining our personal health. In addition, comparable reporting will better inform public policy discussions regarding the role and limitations of the formal health care system in promoting optimal health and well-being in New Brunswick.





**Report of the Auditor General on the Results of Applying Specified Auditing
Procedures to the Province of New Brunswick's Report on Health Performance Indicators**

To the Minister of the Department of Health and Wellness

In connection with the featured indicators included in the Province of New Brunswick report on *Health Performance Indicators* dated November 2004 I have:

1. Agreed information from organizations including Statistics Canada, the Canadian Institute for Health Information and Health Canada, to reports from those organizations.
2. Checked that the presentation of results is consistent with the stated methodology.
3. Where applicable checked that the results presented are comparable to information presented in the 2002 New Brunswick report on *Health Performance Indicators*.
4. Checked that the featured indicators agree to and include results for the eighteen featured indicators approved by the Conference of Deputy Ministers pursuant to the February 5, 2003 First Ministers' Accord on Health Care Renewal.

As a result of applying the above procedures, I found the following exception.

1. As the Department of Health and Wellness has noted in the *About this Report* section of the report on *Health Performance Indicators*, The Province of New Brunswick is unable to report on one of the featured indicators, Prevalence of Diabetes. This is due to the Province of New Brunswick not submitting applicable data until 2003.

These procedures, however, do not constitute an audit and therefore I express no opinion on the featured indicators included in the New Brunswick report on *Health Performance Indicators*.

Daryl Wilson, FCA
Auditor General
November 30, 2004

Office of the Auditor General
P.O. Box 758
Fredericton, New Brunswick E3B 5B4

ABOUT THIS REPORT

What is in this Report

As previously noted, this report includes information on seventeen core comparable health indicators (see Table of Contents). The Plan for comparable indicator reporting identifies eighteen core indicators which all jurisdictions are expected to report on if the necessary data is available. In the second edition of the *HEALTH Performance Indicators* report, New Brunswick is unable to report on one of the core indicators (Prevalence of diabetes), because comparable data is unavailable. Data for the prevalence of diabetes indicator are derived from the National Diabetes Surveillance System (NDSS) and cover the period from 1997/98 to 1999/2000. New Brunswick did not begin submitting data to the NDSS until 2003, and therefore has no comparable data for those years. However, it is anticipated that New Brunswick will be able to report on this indicator in the future.

What is not in the Report

Although the PRTWG recommended only eighteen core indicators for mandatory reporting by all jurisdictions, a total of 70 comparable health indicators have been developed for 2004. A complete list of all of the available comparable health indicators is provided in Appendix A. With the exception of 'Prevalence of diabetes', all indicators designated as "Feature in 2004" are included in this report.

Comparable indicators (featured and non-featured) for all jurisdictions are available on a common national web-site jointly maintained by Statistics Canada and the Canadian Institute for Health Information. Readers interested in viewing New Brunswick's results for the indicators not featured in this report and/or in obtaining additional detail or comparisons for the core indicators may do so by accessing the common web-site at:

<http://www.statcan.ca/english/freepub/82-401-XIE/2002000/index.htm>

or

www.cihi.ca/comparable-indicators

A copy of the Plan as well as detailed technical information on each of the indicators is also available at this site.

Intended Audience and Level of Detail

The target audience for the *HEALTH Performance Indicators* report is the general public of New Brunswick. As a result, the report focuses only on New Brunswick's measurement results compared to those for Canada as a whole. Additionally, to keep the report 'user friendly', the presentation of the indicator data has been simplified as much as possible and many technical details concerning the derivation of the indicators have been omitted. Readers who are interested in examining New Brunswick's results in more detail and/or in learning more about the technical aspects of the various indicators may do so by visiting the web sites noted above.

The focus of the *HEALTH Performance Indicators* report is on presenting quantitative results in a manner that enables readers to compare New Brunswick's performance with respect to the Canadian average and (where possible) to examine how our results have changed over recent years. This report does not include analysis of why particular results may have occurred nor does it address the steps that might be taken to improve performance in the future. A meaningful discussion of these topics would require extensive analysis that is well beyond the scope of this report.

Organization

The seventeen comparable performance indicators in this report are presented under three general headings: Access, Quality and Health and Wellness. There is no particular significance to the order in which the indicators are presented and it should be noted that there are no hard and fast criteria for determining how a particular indicator should be categorized. However, in this report, the division of the seventeen core indicators into the three major categories is based on the work of the PRTWG. The classification scheme used for the complete list of all comparable performance indicators, presented in Appendix A, was also developed by the PRTWG but is not used in this report.

Several of the core indicators are broken down and presented in more than one way. Conversely, in this report, some core indicators have been combined in a single table or chart for presentation purposes. As a result there is no direct one-to-one relationship between the number of core indicators (and sub-indicators) and the number of charts and tables. The data for each measure or related set of measures are presented in a table accompanied by corresponding graphs, technical notes and a brief description and analysis of the results. It should be noted that due to space limitations, graphs are not provided for all aspects of the data contained in the tables.

Data sources

Statistics Canada and the Canadian Institute for Health Information (CIHI) are the sources for all of the indicators presented in the second edition of the *HEALTH Performance Indicators* report. While much of the data for these indicators originated from provincial sources such as hospital records, vital statistics agencies and cancer registries, Statistics Canada and CIHI were responsible for compiling these data into the standardized performance indicators that have been used by all FPT jurisdictions in the preparation of their comparable indicators reports.

A Note on Variability and Statistical Significance

Variability is a statistical term that describes the level of precision obtained when measuring various phenomena, including health-related events or conditions. The following example illustrates this concept.

If Person A goes into a department store and tries out several different weight scales they might find that one scale gives them a weight of 155 pounds, another gives them a weight of 160 pounds, while a third might give them a weight of 157 pounds. The difference in the weights given by the various machines (i.e., 5 pounds) represents the variability associated with the measurement of Person A's weight.

For statistical purposes we would estimate Person A's 'true' weight to be the average of the measures from the three scales - that is 157.3 pounds. However, due to the variability associated with the measurement of Person A's weight we could never be completely certain that Person A's 'true' weight is exactly 157.3 pounds. All that we could conclude is that Person A's 'true' weight is almost certainly somewhere between 155 and 160 pounds.

Each of the performance indicator results in the *HEALTH Performance Indicators* report has a certain level of variability associated with it. Those measures derived from surveys typically have higher levels of variability than measures associated with vital statistics or hospital records. Variability in measurement results comes from several sources including changes in the measurement process. In particular, it should be noted that some of the year to year variation in performance indicators derived from surveys such as the National Population Health Surveys (NPHS) and the Canadian Community Health Survey (CCHS) is likely due to changes in survey methodologies. For example, the proportion of respondents interviewed in person as opposed to by telephone, was higher in the 2001 than in the 2003 round of the CCHS. It is believed that this change in methodology may have influenced the accuracy of some performance indicator measures such as self-reported height and weight (used to calculate Body Mass Index). Therefore, when examining

year-to-year changes in indicator results it is important to consider both the level and sources of variability associated with the measure.

In this edition of the *HEALTH Performance Indicators* report 'true' differences in performance indicator results are designated as being statistically 'significant'. Statistically significant differences are those where we can be at least 95% certain that there is a real or true difference between the two numbers being compared. It should be noted that due to differences in the variability of the performance indicators, a small difference between two numbers for one indicator may be statistically significant, while a much larger difference between two numbers for another indicator may not. In this report wording such as slightly or somewhat higher or lower is sometimes used to describe indicator results. However, unless they are identified as being statistically significant, it should be understood that differences described in this manner may simply be due to random variation in the measures.

Readers who are interested in determining if observed changes or differences are statistically significant are encouraged to visit the Statistics Canada or CIHI web sites to obtain the variability (i.e., confidence interval) information required to perform the necessary statistical calculations.

A Note on Interpreting Single Period Results

In addition to exercising caution when interpreting the significance of observed changes over time or differences between jurisdictions on the various indicators, readers are also reminded that caution should be exercised when interpreting results which are based on a single measurement period. As is evident when examining the results from indicators where a long time trend is available, there can be considerable year-to-year variability in results, particularly at the provincial level. Therefore, readers should be conservative in their conclusions with respect to any indicators that have results from only one time period.

ACCESS

Highlights

The five indicators presented in this section are intended to reflect New Brunswick's access to health care services. These indicators focus on several factors which might negatively impact on access to services, including availability of services, waiting times, and costs.

In general, New Brunswickers appear to enjoy the same level of access to basic health care services as Canadians on average. Both New Brunswickers and Canadians in general were more likely to report having difficulty accessing immediate care for a minor health problem, than difficulty accessing health information or advice or routine, ongoing health care services.

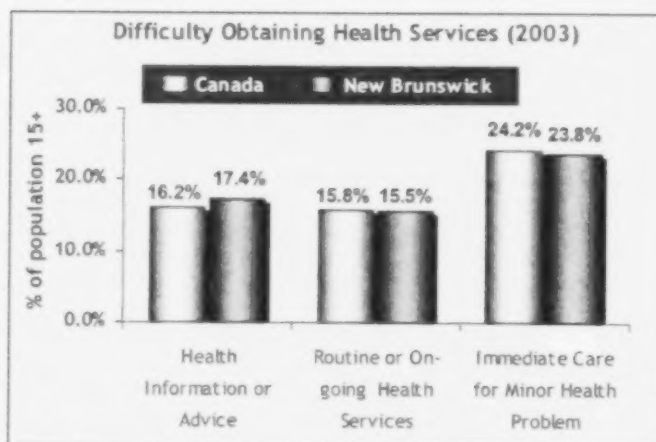
New Brunswickers experienced similar wait times as other Canadians for diagnostic services, with over half receiving required services in less than one month, and less than 12% waiting for more than three months.

The only measure where New Brunswickers differed significantly from Canadians on average, dealt with out-of-pocket spending for prescription drugs. New Brunswickers were more likely than Canadians on average to have at least some out-of-pocket spending for prescription drugs; and in recent years the percentage of households with out-of-pocket spending greater than five percent of after-tax income was higher in New Brunswick than in Canada overall.

Difficulty Obtaining Health Services

As part of Statistics Canada's 2003 Health Services Access Survey (HSAS), a random sample of New Brunswickers and other Canadians aged 15 and over, who reported requiring three different types of health services for themselves or a family member over the preceding twelve months, were asked about difficulties they experienced in obtaining these services. The reasons why someone might have reported experiencing 'difficulty' obtaining health services were numerous and included difficulties such as transportation, cost and family responsibilities. However, the most frequently reported difficulties in obtaining health services were associated with waiting times and availability of services.

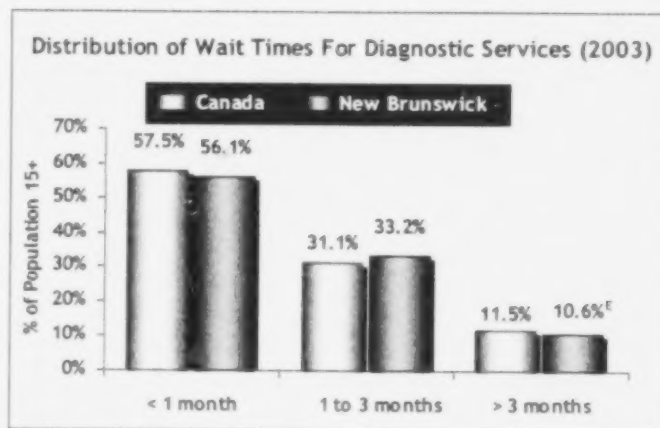
There was very little difference in the percentage of New Brunswickers, and Canadians overall, who reported experiencing difficulty in obtaining either: Health information or advice; Routine or ongoing health services or; Immediate care for a minor health problem. On average, about 24% of respondents who required immediate care for a minor health problem reported experiencing some form of difficulty in obtaining that service. Respondents who required health information or advice or routine or ongoing care, were less likely to have experienced difficulties in obtaining those services.



Self-Reported Wait Times for Diagnostic Services

The HSAS also asked respondents who had received a non-emergency MRI, CT Scan or angiography in the preceding 12 months, how long they had waited to receive the test.

There was little difference between the New Brunswick and Canadian wait time results. Over half of all respondents waited less than a month for their test and only about 12% waited more than three months.



^E Use with Caution

Difficulty Obtaining Health Services:

By Type of Service

Canada and New Brunswick (2003): Percentage of Population 15+ (Who Require the Service)

Type of Service	Canada	New Brunswick
Health Information or Advice	16.2%	17.4%
Routine or On-going Health Services	15.8%	15.5%
Immediate Care for Minor Health Problem	24.2%	23.8%

*Source: Statistics Canada, Health Services Access Survey 2003***Difficulty Obtaining Health Information or Advice**

Percentage who required health information or advice for self or a family member in the past 12 months and experienced difficulty obtaining it at any time of day.

Difficulty Obtaining Routine or On-going Health Services

Percentage who required routine or on-going health services for self or a family member in the past 12 months and experienced difficulties obtaining them at any time of day

Difficulty Obtaining Immediate Care

Percentage who required immediate care for a minor health problem for self or a family member in the past 12 months and experienced difficulty obtaining it at any time of day.

Self-reported wait times for diagnostic services:

By Median and Distribution of Wait Times

Canada and New Brunswick 2003, Percentage of Population 15+ (Who Received Diagnostic Test)

Wait Time Measure	Canada	New Brunswick
Median wait time (weeks)	3	2 ^E
Distribution of Wait Times		
< 1 month	57.5%	56.1%
1 to 3 months	31.1%	33.2%
> 3 months	11.5%	10.6% ^E

(Source: Statistics Canada, Health Access Survey 2003)^E: Use with caution

Wait time refers to the length of time, in weeks, between the patient being referred for a specialized service and receiving the service, during the 12 months prior to the survey. Patients who had been referred for the service but who had not yet received it, were excluded from the indicator calculations.

Median wait time for diagnostic services

The median is the 50th percentile of the distribution of wait times: half the patients wait less and half wait longer than the median number of weeks

Distribution of wait times for diagnostic services

The percent of those requiring a diagnostic service that waited less than 1 month, between 1 and 3 months or more than 3 months to receive the service, during the 12 months prior to the survey.

Prescription Drug Spending as a Percentage of Income

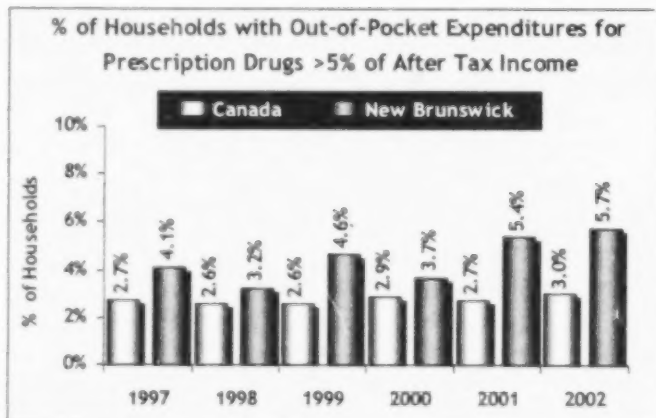
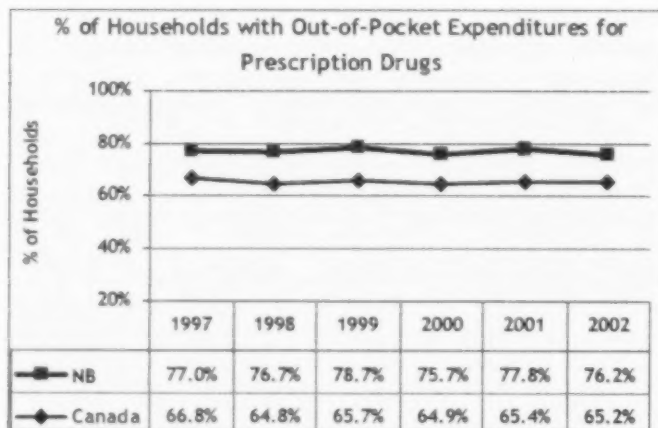
This indicator provides a measure of the extent to which New Brunswickers pay, out-of-pocket, for their prescription medications. Out-of-pocket expenditures could include paying the full amount for a prescription or paying the 'co-pay' amount that is not covered by an insurance plan. These expenditures do not include the premium payments for a prescription drug plan, nor payments for over-the-counter medications.

Between 1997 and 2002 roughly three quarters of all New Brunswick households had some (i.e., > 0%) out-of-pocket spending for prescription drugs. By comparison, in Canada on average about 65% of households had some out-of-pocket spending on prescription drugs.

As well as being more likely to spend some out-of-pocket income on prescription drugs, in 2001 and 2002 New Brunswickers were also significantly more likely, than Canadians on average, to spend more than 5% of their out-of-pocket, after-tax income on prescription drugs.

Between 1997 and 2002 there appears to have been a gradual upward trend in the percentage of New Brunswick households which spent more than 5% of out-of-pocket after tax income on prescription drugs.

These results suggest that obtaining prescription drugs may involve more of a financial commitment for New Brunswick households than households in other parts of the country. However, it should be noted that these findings do not necessarily imply that New Brunswickers have less access to prescription drugs - only that they are more likely to have to pay out-of-pocket for them.



Prescription Drug Spending as a Percentage of Income

Percentage of households spending over given percentages (0%, 1%, 2%, 3%, 4% and 5%) of total after tax income out-of-pocket on prescription drugs.

Prescription drug spending as a percentage of household income: By Year and Level of Out-of-Pocket Expenditures, Canada and New Brunswick (1997 - 2002): Percentage of Households						
Out-of-Pocket Spending on Prescription Drugs	1997	1998	1999	2000	2001	2002
Canada						
> 0% of after tax income	66.8%	64.8%	65.7%	64.9%	65.4%	65.2%
> 1% of after tax income	18.1%	17.7%	19.0%	19.0%	18.6%	19.1%
> 2% of after tax income	9.4%	9.0%	10.0%	10.3%	10.2%	10.5%
> 3% of after tax income	5.9%	5.8%	6.1%	6.3%	6.2%	6.5%
> 4% of after tax income	3.8%	3.9%	4.0%	4.0%	3.8%	4.5%
> 5% of after tax income	2.7%	2.6%	2.6%	2.9%	2.7%	3.0%
New Brunswick						
> 0% of after tax income	77.0%	76.7%	78.7%	75.7%	77.8%	76.2%
> 1% of after tax income	24.6%	24.8%	25.1%	25.7%	26.4%	26.7%
> 2% of after tax income	13.6%	12.8%	13.6%	13.6%	16.6%	15.6%
> 3% of after tax income	8.0%	8.0%	9.0%	8.5%	11.0%	10.2%
> 4% of after tax income	5.1%	4.9%	5.8%	6.1%	7.0%	8.0%
> 5% of after tax income	4.1%	3.2%	4.6%	3.7%	5.4%	5.7%

Source: Statistics Canada, Survey of Household Spending 1997, 1998, 1999, 2000, 2001, 2002

Persons living on First Nation Reserves and on Crown lands, residents of institutions, full-time members of Canadian Armed Forces, and residents of certain remote regions are excluded from the Survey on Household Spending. Data from the territories are not available due to data quality issues.

Prescription Drug Spending as a Percentage of Income

This indicator provides a measure of the extent to which New Brunswickers pay, out-of-pocket, for their prescription medications. Out-of-pocket expenditures could include paying the full amount for a prescription or paying the 'co-pay' amount that is not covered by an insurance plan. These expenditures do not include the premium payments for a prescription drug plan, nor payments for over-the-counter medications.

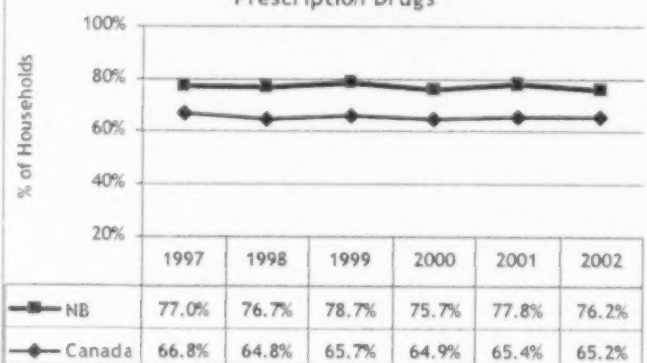
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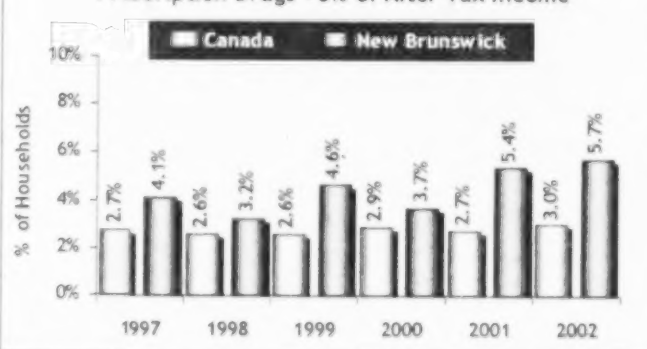
Between 1997 and 2002 there appears to have been a gradual upward trend in the percentage of New Brunswick households which spent more than 5% of out-of-pocket after tax income on prescription drugs.

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% of Households with Out-of-Pocket Expenditures for Prescription Drugs



% of Households with Out-of-Pocket Expenditures for Prescription Drugs >5% of After Tax Income



Prescription Drug Spending as a Percentage of Income

Percentage of households spending over given percentages (0%, 1%, 2%, 3%, 4% and 5%) of total after tax income out-of-pocket on prescription drugs.

Prescription drug spending as a percentage of household income: By Year and Level of Out-of-Pocket Expenditures, Canada and New Brunswick (1997 - 2002): Percentage of Households						
Out-of-Pocket Spending on Prescription Drugs	1997	1998	1999	2000	2001	2002
Canada						
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> 2% of after tax income	9.4%	9.0%	10.0%	10.3%	10.2%	10.5%
> 3% of after tax income	5.9%	5.8%	6.1%	6.3%	6.2%	6.5%
> 4% of after tax income	3.8%	3.9%	4.0%	4.0%	3.8%	4.5%
> 5% of after tax income	2.7%	2.6%	2.6%	2.9%	2.7%	3.0%
New Brunswick						
> 0% of after tax income	77.0%	76.7%	78.7%	75.7%	77.8%	76.2%
> 1% of after tax income	24.6%	24.8%	25.1%	25.7%	26.4%	26.7%
> 2% of after tax income	13.6%	12.8%	13.6%	13.6%	16.6%	15.6%
> 3% of after tax income	8.0%	8.0%	9.0%	8.5%	11.0%	10.2%
> 4% of after tax income	5.1%	4.9%	5.8%	6.1%	7.0%	8.0%
> 5% of after tax income	4.1%	3.2%	4.6%	3.7%	5.4%	5.7%

Source: Statistics Canada, Survey of Household Spending 1997, 1998, 1999, 2000, 2001, 2002

Persons living on First Nation Reserves and on Crown lands, residents of institutions, full-time members of Canadian Armed Forces, and residents of certain remote regions are excluded from the Survey on Household Spending. Data from the territories are not available due to data quality issues.

QUALITY

Highlights

The seven indicators presented in this section measure various aspects of the quality of New Brunswick's health care system. Quality is a difficult concept to measure because it has both objective and subjective dimensions. The core indicators reported in this section focus on patient satisfaction and appropriate delivery of health care services.

New Brunswickers are generally well satisfied with the way that health care services are provided; and our satisfaction ratings are higher than the Canadian average. For each of five aspects of health care examined, over 87% of New Brunswickers were either very or somewhat satisfied with the way that services were provided.

New Brunswick's results on two measures associated with appropriate delivery of health care or 'best practices', were somewhat less positive.

Although it has fallen substantially over the past seven years, New Brunswick's hospitalization rate for ambulatory care sensitive conditions remains significantly higher than the national average; reflecting a possible over-reliance on inpatient as opposed to community-based care.

New Brunswick's rate of immunization against the flu among seniors was also significantly lower than the national average; reflecting potential missed opportunity for preventing avoidable illness.

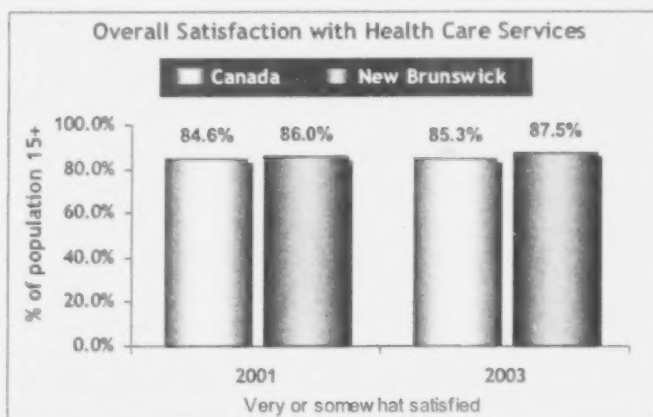
Quality

Satisfaction with Health Care Services

A random sample of New Brunswickers and other Canadians who took part in the Canadian Community Health Surveys in 2001 and 2003 and who had received various health care services in the twelve months prior to the survey, were asked to rate their level of satisfaction with the way those health care services had been provided. Respondent's ratings of hospital and physician care were based on only their most recent experience in receiving those health care services.

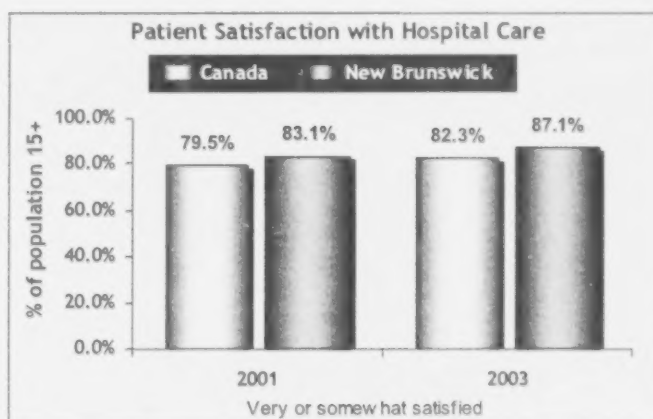
Patient Satisfaction with Overall Health Care Services

There was little difference between New Brunswickers and Canadians overall satisfaction with the way that health care services had been provided, nor any substantial change in the satisfaction ratings between 2001 and 2003. Overall, the vast majority of respondents who received health care services were either very or somewhat satisfied with the way those services had been provided.



Patient Satisfaction with Hospital Care

Both in 2001 and 2003, the percentage of respondents who were either satisfied or very satisfied with the way hospital services had been provided, was slightly higher in New Brunswick than in Canada as a whole. In 2003, roughly 82% of Canadians and 87% of New Brunswickers who had received hospital care in the preceding twelve months were either very or somewhat satisfied with the way that care was provided.



Patient Satisfaction with Physician Care

New Brunswickers and Canadians overall reported a uniformly high level of satisfaction with the way in which physician care was provided outside of the hospital setting. Over ninety percent of those who had received physician care outside of a hospital during the twelve months prior to being surveyed were either very or somewhat satisfied with the way in which physician care was provided.



Patient Satisfaction With Overall Health Care Services

Percentage of the population aged 15 and over who rate themselves as either very satisfied or somewhat satisfied with the overall health care services received.

Patient satisfaction with overall health care services				
By year				
Canada and New Brunswick: Percentage of Population 15+ (Who Received Health Care Services)				
Rating	Canada		New Brunswick	
	2001	2003	2001	2003
Very or Somewhat Satisfied	84.6%	85.3%	86.0%	87.5%

Source: Statistics Canada, Canadian Community Health Survey 2001 and 2003

For health care services, the following question was asked: Overall, how satisfied were you with the way health care services were provided? Were you: ... very satisfied? ... somewhat satisfied? ... neither satisfied nor dissatisfied? ... somewhat dissatisfied? ...very dissatisfied?

Patient Satisfaction with Hospital Care

Percentage of the population aged 15 and over who rate themselves as either very satisfied or somewhat satisfied with the way hospital services were provided

Patient satisfaction with hospital care				
By year				
Canada and New Brunswick: Percentage of Population 15+ (Who Received Hospital Care)				
Rating	Canada		New Brunswick	
	2001	2003	2001	2003
Very or Somewhat Satisfied	79.5%	82.3%	83.1%	87.1%

Source: Statistics Canada, Canadian Community Health Survey 2001 and 2003

Patient Satisfaction with Physician Care

Percentage of population 15 years old and older who rate themselves as either very satisfied or somewhat satisfied with the care received from a physician - family doctor or medical specialist (excluding services received in a hospital).

Patient satisfaction with physician care				
By year				
Canada and New Brunswick: Percentage of population 15+ (Who Received Physician Care)				
Rating	Canada		New Brunswick	
	2001	2003	2001	2003
Very or Somewhat Satisfied	90.9%	91.8%	92.3%	93.2%

Source: Statistics Canada, Canadian Community Health Survey 2001 and 2003)

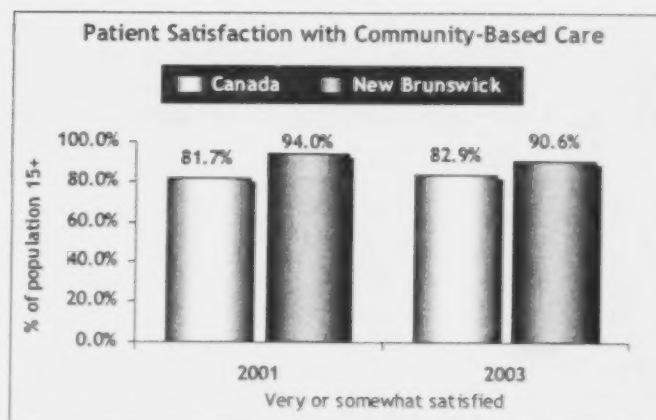
For hospital and physician care, respondents were asked if they were: ... very satisfied?... somewhat satisfied? ... neither satisfied nor dissatisfied? ... somewhat dissatisfied?... very dissatisfied? with the way in which the service was provided.

Persons living on First Nation Reserves and on Crown lands, residents of institutions, full-time members of Canadian Armed Forces, and residents of certain remote regions are excluded from the calculation of all three indicators. Persons under 15 years of age were not asked the questions about satisfaction with these health care services.

Respondents who took part in the 2001 and 2003 Canadian Community Health Surveys and who reported receiving community-based health care services in the 12 months prior to the surveys were asked about their satisfaction with the way in which those services were provided. The CCHS definition of 'community-based care' includes any health care received outside of a hospital or doctor's office, such as home nursing care, home-based counselling or therapy, personal care, community walk-in clinics, etc.

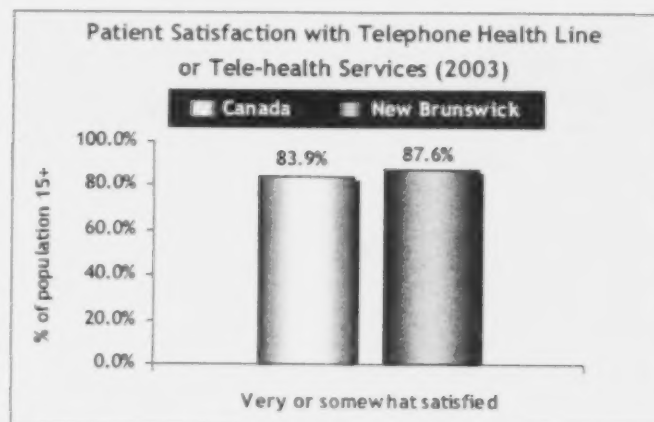
Patient Satisfaction with Community-Based Care

In 2001 and 2003, the percentages of respondents who were either very or somewhat satisfied with the way in which community-based care was provided, were significantly higher in New Brunswick than in Canada overall. Although the percentage of New Brunswickers who were very or somewhat satisfied decreased slightly between 2001 and 2003, this change was not statistically significant.



Patient Satisfaction with Telephone Health Line or Tele-Health Services

CCHS participants were asked about their satisfaction with the way in which telephone health line or tele-care services were provided for the first time in 2003. The percentage of telephone health line or tele-care users who were either very or somewhat satisfied with the way in which the service was provided was similar in New Brunswick and Canada as a whole.



Patient Satisfaction with Community-Based Care

Percentage of the population aged 15 and over who rate themselves as either very satisfied or somewhat satisfied with community-based services received.

Patient satisfaction with community-based care				
By year				
Canada and New Brunswick: Percentage of Population 15+ (Who received community-based care)				
Rating	Canada		New Brunswick	
	2001	2003	2001	2003
Very or Somewhat Satisfied	81.7%	82.9%	94.0%	90.6%

Source: Statistics Canada, Canadian Community Health Survey 2001 and 2003

For community-based care, the following question was asked: Overall, how satisfied were you with the way community-based care was provided? Were you: ... very satisfied? ... somewhat satisfied? ... neither satisfied nor dissatisfied? ... somewhat dissatisfied? ...very dissatisfied?

Persons living on First Nation Reserves and on Crown lands, residents of institutions, full-time members of Canadian Armed Forces, and residents of certain remote regions are excluded from the sample. Persons less than 15 years of age are not asked this question.

Patient Satisfaction with Telephone Health Line or Tele-Health Services

Percentage of the population aged 15 and over who rate themselves as either very satisfied or somewhat satisfied with the telephone health line or tele-health service received.

Patient satisfaction with telephone health line or tele-health services:		
Canada and New Brunswick (2003): Percentage of Population 15+ (Who Received Telephone Health Line or Tele-Health Services)		
Rating	Canada	New Brunswick
Very or somewhat satisfied	83.9%	87.6%

Source: Canadian Community Health Survey: 2003.

For tele-health services, the following question was asked: Overall, how satisfied were you with the way the tele-health service was provided? Were you: ... very satisfied? ... somewhat satisfied? ... neither satisfied nor dissatisfied? ... somewhat dissatisfied? ...very dissatisfied?

Persons living on First Nation Reserves and on Crown lands, residents of institutions, full-time members of Canadian Armed Forces, and residents of certain remote regions are excluded from the sample. Persons less than 15 years of age are not asked this question.

Hospitalization Rate for Ambulatory Care Sensitive Conditions

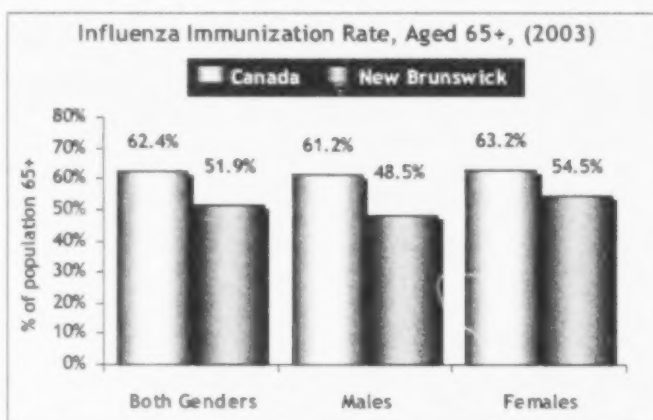
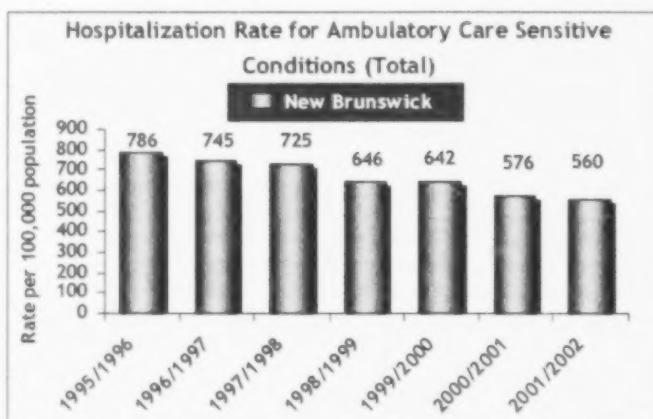
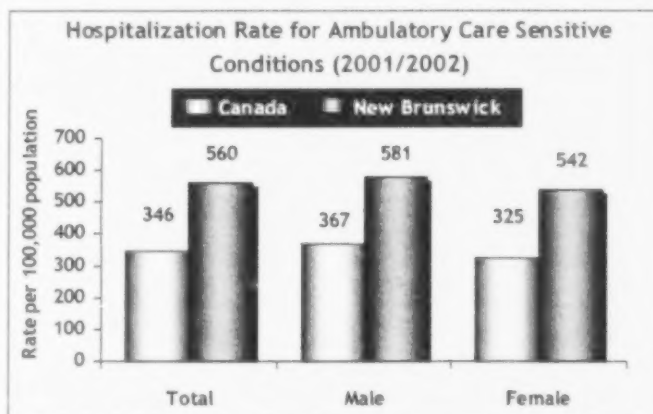
Ambulatory care sensitive conditions (ACSC) are conditions such as diabetes, asthma, alcohol and drug abuse, neuroses, depression and hypertension, for which effective out-patient and community-based care may reduce the need for hospitalization. Hospitalization rates for these conditions are one indicator of the quality and availability of preventative, primary and community-based care. Health care professionals generally believe that managing these conditions before a patient requires hospitalization improves the patient's health and contributes to better overall community health status.

In 2001/02, New Brunswick's hospitalization rate for ACSC was significantly higher than the Canadian average for both men and women. However, since 1995/1996, New Brunswick's hospitalization rate for ACSC has fallen substantially.

Immunization for Influenza Aged 65 plus ("Flu Shot")

This indicator shows the percentage of Canadians and New Brunswickers aged 65 years and older who reported having had a flu shot in the past year. The percentage of CCHS respondents who reported having had a flu shot in 2003 was significantly lower in New Brunswick than in Canada overall. This finding was consistent in both males and females.

Vaccination is recognized as the single most effective way of preventing the flu or reducing the severity of its symptoms. The influenza immunization rate among New Brunswickers aged 65 and over, provides information about the effectiveness of the health care system's primary prevention and educational programs.



Hospitalization Rate for Ambulatory Care Sensitive Conditions

Age-standardized inpatient hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to hospital.

Hospitalization rate for ambulatory care sensitive conditions						
By Gender and year						
Canada and New Brunswick (1995 - 2002): Rate per 100,000 population†						
Year	Canada			New Brunswick		
	Total	Male	Female	Total	Male	Female
1995/1996	503	513	492	786	752	810
1996/1997	463	475	450	745	722	765
1997/1998	447	461	431	725	712	738
1998/1999	411	425	397	646	643	647
1999/2000	401	418	383	642	660	624
2000/2001	370	389	352	576	581	571
2001/2002	346	367	325	560	581	542

Source: CIHI Canada

† All rates are age-standardized according to the 1991 Canadian population.

Caution is advised when comparing Canadian 2001/02 rates with previous years because some differences may be associated with the implementation of the ICD-10-CA/CCI coding system in some provinces. However, ICD-10-CA/CCI was not introduced in New Brunswick until 2003.

Immunization for Influenza Aged 65 plus ("Flu Shot")

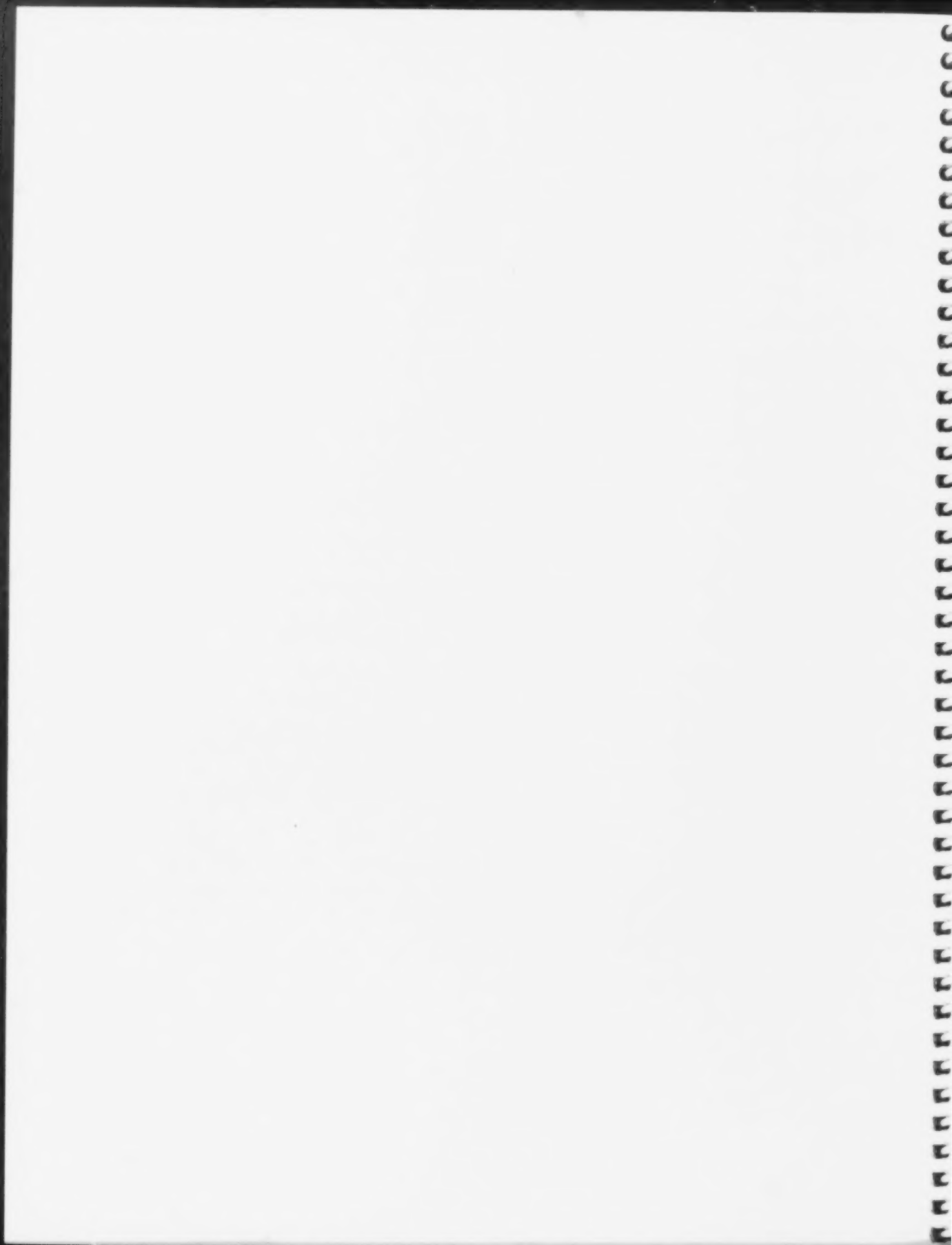
Proportion of population 65 and over who report having a flu shot in the past year.

Immunization for Influenza ("Flu Shot"):						
By Gender						
Canada and New Brunswick (2003): Percent of Population 65+						
Immunized ^a For Influenza	Canada			New Brunswick		
	Both Genders	Males	Females	Both Genders	Males	Females
Less Than 1 Year Ago	62.4%	61.2%	63.2%	51.9%	48.5%	54.5%

Source: Statistics Canada, Canadian Community Health Survey (sub sample) Cycle 2.1, 2003

This indicator reports time of last immunization. The questions asked to a sub-sample of CCHS participants were: Have you ever had a flu shot? When did you have your last flu shot?

Persons living on First Nation Reserves and on Crown lands, residents of institutions, full-time members of Canadian Armed Forces and residents of certain remote regions are excluded from the sample.



HEALTH & WELLNESS

Highlights

This section includes five measures of the health and wellness of the New Brunswick population. The first two measures deal with general or overall health while the remaining three focus on specific health related behaviors.

On Health Adjusted Life Expectancy (HALE), which is an objective measure of general health, New Brunswickers were similar to the Canadian average. However on self-reported health, which is a more subjective measure of wellness, New Brunswickers were significantly less likely than Canadians in general, to rate their health as very good or excellent.

On teenage smoking, New Brunswick was similar to the national average, although teenage boys in New Brunswick were somewhat more likely to be daily smokers than teenage boys in Canada as a whole.

New Brunswick fared poorly on measures of physical activity and healthy body weight. On both indicators, New Brunswickers were significantly less likely to demonstrate healthy lifestyle attributes, than Canadians on average. These findings reflect a long standing trend of poor lifestyle habits in New Brunswick.

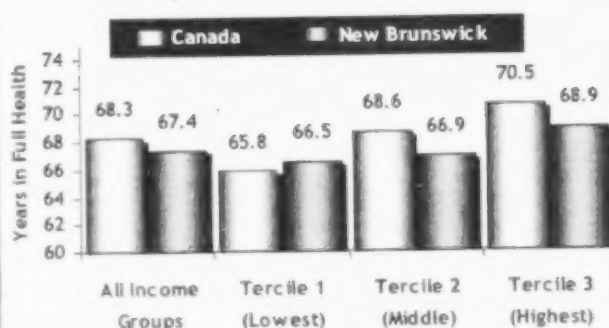
Health and Wellness

Health Adjusted Life Expectancy (HALE)

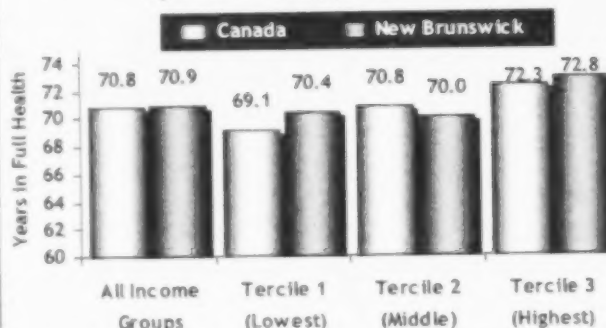
Health Adjusted Life Expectancy (HALE) combines measures of population health and life expectancy to provide a standardized statistical indicator of the extent to which members of a population can expect to live their lives in full health. In this sense, HALE is a measure of both the quantity and quality of life.

Income terciles are a measure of relative wealth: Individuals in tercile 1 have incomes in the lowest third of the income range for the population; those in tercile 2 have incomes in the middle third and so on. An examination of HALE in relationship to gender and income, illustrates the impact of these factors on health and longevity and may provide an indication of the potential for improving health and wellness among those segments of the population with lower HALE.

Health Adjusted Life Expectancy (HALE) (At Birth):
By Income Group(2001): Males



Health Adjusted Life Expectancy (HALE) (At Birth):
By Income Group(2001): Females



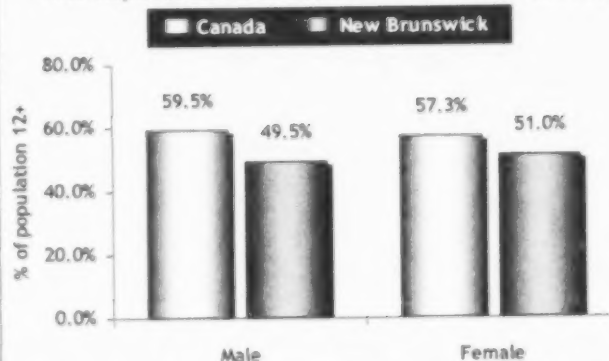
Due to their longer life expectancy, women typically have a higher HALE than men. The positive correlation between income and HALE was less pronounced in NB males than in Canadian men overall, and NB men in the highest income tercile have a significantly lower HALE than NB women in the highest income group. NB men in the highest income group do, however have a significantly higher HALE than NB or Canadian men in the lowest tercile.

Self-Reported Health

Self-reported health is a subjective measure of the overall health status of individuals. It has been found to be a good predictor of chronic disease incidence, functional decline and ultimate survival.

In 2003, the percentage of New Brunswick men and women who rated their health as very good or excellent was significantly lower than the corresponding Canadian averages.

Self-Reported Health Very Good or Excellent (2003)



Health Adjusted Life Expectancy (HALE)

Health adjusted life expectancy is the number of years in full health, that an individual can expect to live given the current morbidity and mortality conditions.

Health Adjusted Life Expectancy (HALE) (At Birth):

By Gender and Income Group,

Canada and New Brunswick (2001): Expected Years of Life in Full Health

Income Group	Canada		New Brunswick	
	Males	Females	Males	Females
All Income Groups	68.3	70.8	67.4	70.9
Tercile 1 (Lowest)	65.8	69.1	66.5	70.4
Tercile 2 (Middle)	68.6	70.8	66.9	70
Tercile 3 (Highest)	70.5	72.3	68.9	72.8

Source: NPHS, Institutional Component for HUI of persons in institutions (1996-1997 cross-sectional sample), 2001 Census for counts of residents living in long-term health care institutions (to match with sampling frame of the NPHS), CCHS Cycle 1.1 (common content) for HUI and counts of persons in households. 2000/2001 abridged life tables adjusted to 1996 income terciles.

As with life expectancy, HALE is a standardized statistical indicator. It is not the number of full health equivalent years a particular newborn (or person currently age 65) can actually expect to live. The reason is that mortality rates and levels of health status only for the observation period (e.g. 2001) are used, and these are averages for the entire population.

The National Population Health Survey Institutional component collects data on long-term residents (expected to stay six months or more) living in health care institutions with four or more beds. Institutions that exclusively provided short-term care, such as drug rehabilitation centres were excluded. Health care institutions on Indian reservations and Canadian Forces Bases or within correctional facilities were excluded.

Self-Reported Health

Percentage of the population aged 12 and older who report that their health is very good or excellent.

Self-reported health very good or excellent:

Canada and New Brunswick (1994 -2003): Percentage of Population 12+

Year	Canada		New Brunswick	
	Male	Female	Male	Female
1994-1995	65.4%	60.8%	58.3%	55.3%
1996-1997	65.3%	61.6%	60.0%	55.6%
1998-1999	67.3%	63.2%	59.3%	54.3%
2000-2001	62.9%	59.9%	56.3%	54.9%
2003	59.5%	57.3%	49.5%	51.0%

Source: Statistics Canada, Canadian Community Health Survey, 2000/01 and 2003; National Population Health Survey, 1994/95, 1996/97, and 1998/99.

For self-reported health, the following question was asked: In general, would you say your health is: ... excellent? ... very good? ...good? ... fair? or ...poor?

Persons living on First Nation Reserves and on Crown lands, residents of institutions, full-time members of Canadian Armed Forces, residents of certain remote regions and persons less than 12 years of age are excluded from the CCHS and NPHS samples for HALE and self-reported health indicators.

Teenage Smoking Rates

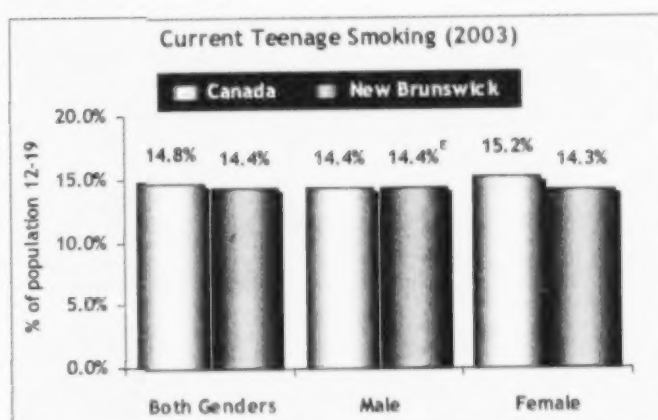
Tobacco use is the leading cause of preventable illness and death in Canada. Because of the addictive nature of nicotine, youth smoking is of particular concern. The majority of smokers begin the habit during their teenage years. It is estimated that approximately eight out of every 10 people who try smoking become habitual smokers.

This indicator reports on the percentage of CCHS respondents between the ages of 12 and 19, who reported being regular or occasional smokers at the time they were interviewed. Current smokers, includes both regular and occasional smokers.

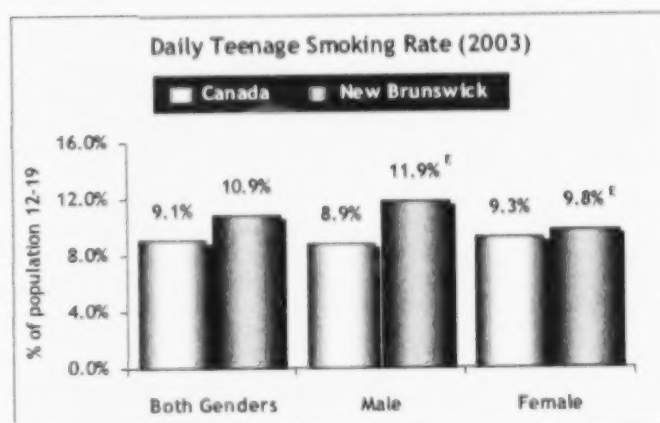
In 2003 the percentage of male and female teenagers classified as current smokers was similar in New Brunswick and Canada overall.

The percentage of male teenagers who were classified as daily smokers was somewhat higher in New Brunswick than in Canada as a whole. The percentage of female teenagers classified as regular smokers was similar in New Brunswick and Canada overall. Male teenagers in New Brunswick were more likely to report being regular smokers than were their female counterparts.

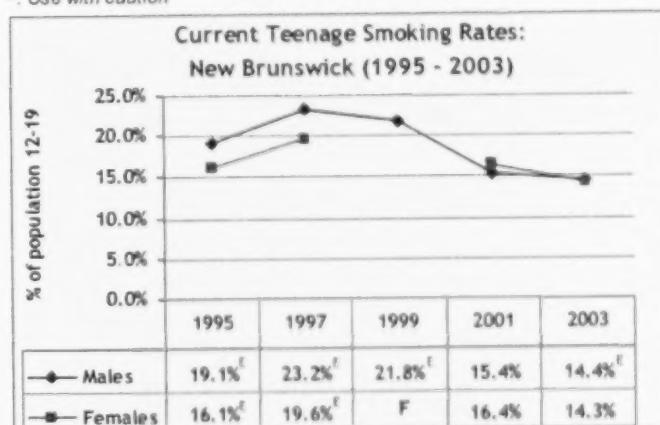
Year to year changes in teenage smoking rates must be interpreted with caution because changes in survey methods have been found to influence rate estimates. However, it appears that teenage smoking rates in New Brunswick have declined in recent years.



E: Use with caution



E: Use with caution



E: Use with caution

F: Data too unreliable to be published

Teenage Smoking Rates: Proportion of Current and Daily Teenage Smokers

Percentage of population aged 12 - 19 (inclusive) reporting they are current smokers (current includes daily and occasional smokers) at the time of the interview and percentage of population aged 12 - 19 (inclusive) reporting they are daily smokers at the time of the interview.

Teenage Smoking Rates:

By Gender and Smoking Status

Canada and New Brunswick (2003): Percentage of Population 12 - 19

Smoking Status	Canada			New Brunswick		
	Both Genders	Male	Female	Both Genders	Male	Female
Current Smoker	14.8%	14.4%	15.2%	14.4%	14.4% ^E	14.3%
Daily Smoker	9.1%	8.9%	9.3%	10.9%	11.9% ^E	9.8% ^E

Source: Statistics Canada, Canadian Community Health Survey 2003

^E: Use with caution

Current Teenage Smoking Rates:

By Gender

New Brunswick (1995 - 2003): Percentage of Population 12 - 19

Gender	New Brunswick				
	1995	1997	1999	2001	2003
Males	19.1% ^E	23.2% ^E	21.8% ^E	15.4%	14.4% ^E
Females	16.1% ^E	19.6% ^E	F	16.4%	14.3%

Source: Statistics Canada, Canadian Community Health Survey, 2000/01 and 2003; National Population Health Survey, 1994/95, 1996/97, and 1998/99.

^E: Use with caution

^F: Data too unreliable to be published

The data are based on the question: At the present time do you smoke cigarettes daily, occasionally or not at all?

Persons living on First Nation Reserves and on Crown lands, residents of institutions, full-time members of Canadian Armed Forces and residents of certain remote regions are excluded from the sample.

Physical Activity

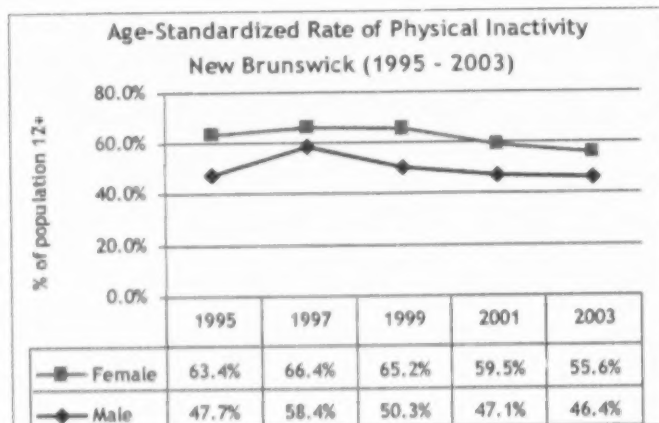
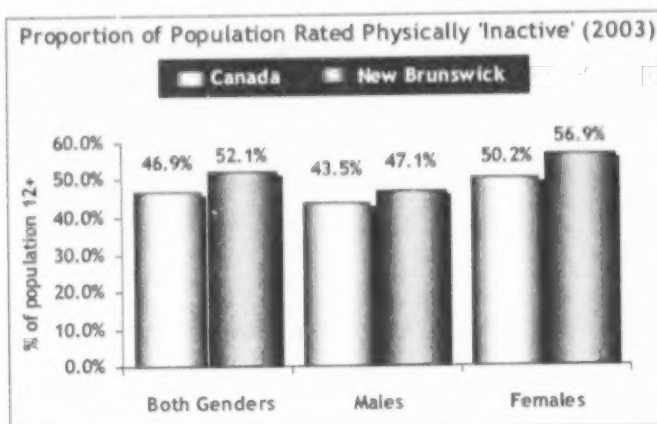
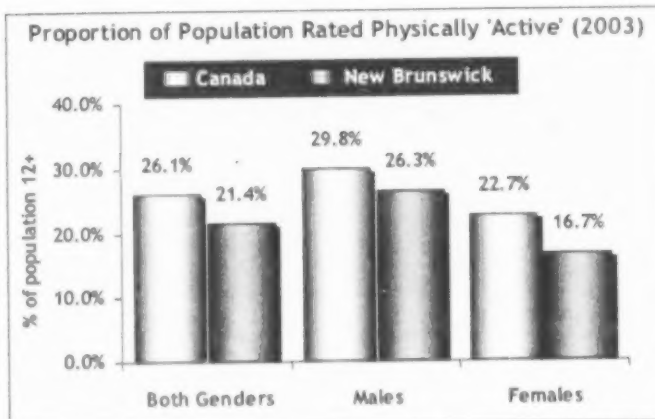
Maintaining physical activity is associated with a range of health benefits. Many studies have shown that regular physical activity confers major heart health benefits and that inactivity is a major risk factor for heart disease. Recent research also shows that physically active individuals are less likely to become depressed.

This indicator reports on the percentage of CCHS respondents 12 years of age and over who were classified as being physically active or inactive based on their self-reported leisure time physical activity levels during the three months prior to being interviewed.

In 2003, the percentage of males and females categorized as physically active, was significantly lower in New Brunswick, than in Canada overall. New Brunswick females were also significantly less likely than New Brunswick males, to be categorized as physically active.

Conversely, the percentage of males and females categorized as physically inactive was significantly higher in New Brunswick, than in Canada overall. New Brunswick females were significantly more likely than New Brunswick males to be categorized as physically inactive.

Year to year changes in physical inactivity rates must be interpreted with caution because changes in survey methods have been found to influence rate estimates. However, it appears that physical inactivity levels in New Brunswick have shown a slight downward trend in recent years.



Physical Activity

- a) Percentage of population aged 12 and over who report a physical activity index of "active".
b) Percentage of population aged 12 and over who report a physical activity index of "inactive".

Physical Activity:

By Physical Activity Index and Gender

Canada and New Brunswick (2003): Percentage of Population 12+

Physical Activity Index	Canada			New Brunswick		
	Both Genders	Males	Females	Both Genders	Males	Females
Physically active	26.1%	29.8%	22.7%	21.4%	26.3%	16.7%
Physically inactive	46.9%	43.5%	50.2%	52.1%	47.1%	56.9%

Source : Statistics Canada, Canadian Community Health Survey 2003

The physical activity index is based on an individual's energy expenditure (EE). EE is calculated using the frequency and duration per session of physical activity, as well as the MET (metabolic) value. The MET is the energy cost of the activity expressed as kilocalories expended per kilogram of body weight per hour of activity, doing a physical activity during the past 3 months, the number of times and time spent on each activity. The derived physical activity index results in the three categories: Active, Moderate and Inactive

Age-Standardized Physically Inactive Rate:

By Gender

New Brunswick (1995 - 2003): Percentage of Population 12 +

Gender	New Brunswick				
	1995	1997	1999	2001	2003
Male	47.7%	58.4%	50.3%	47.1%	46.4%
Female	63.4%	66.4%	65.2%	59.5%	55.6%

Source : Statistics Canada, Canadian Community Health Survey, 2000/01 and 2003; National Population Health Survey, 1994/95, 1996/97, and 1998/99.

Age-standardization allows for better comparison between years and gender groups by controlling for the aging of the population and differences in the proportions of older and younger individuals in the gender groups.

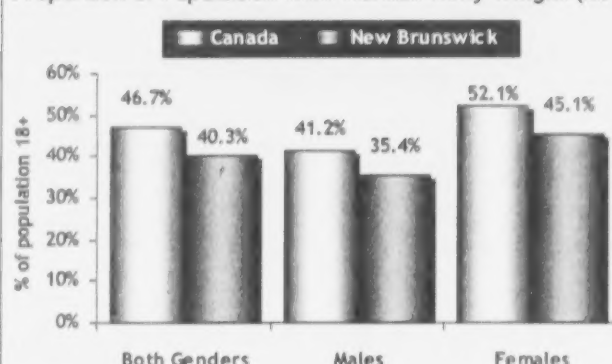
Persons living on First Nation Reserves and on Crown lands, residents of institutions, full-time members of Canadian Armed Forces and residents of certain remote regions are excluded from the calculation of these indicators.

Health and Wellness

Body Mass Index

Obesity has been identified as a major risk factor contributing to a number of chronic illnesses such as diabetes and heart disease. Body Mass Index (BMI) is the most common method of determining if an individual's weight is in a healthy range. The effect of excess weight as a risk factor for various diseases increases with BMI above the threshold of 25; this is a widely used standard in the health literature.

Proportion of Population with 'Normal' Body Weight (2003)



This indicator reports on the percentage of CCHS respondents over the age of 18, excluding pregnant women, with a computed BMI in various categories. BMI calculations are based on the self-reported height and weight of survey respondents.

In 2003, the percentage of males and females with a BMI in the 'normal' range was significantly lower in New Brunswick, than in Canada overall. Additionally, in both New Brunswick and Canada, the percentage of males with a normal BMI was significantly lower than the percentage of females with a normal BMI.

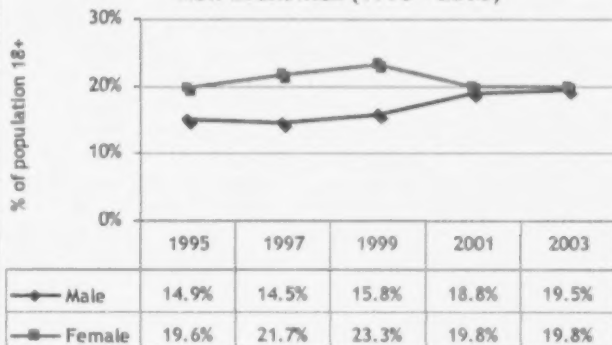
In 2003, the percentage of New Brunswick males and females categorized as overweight was only about two percentage points higher than the corresponding Canadian averages. However, NB men and women were significantly more likely, than Canadian men and women on average, to be categorized as obese.

Year to year changes in obesity rates must be interpreted with caution because changes in survey methods have been found to influence rate estimates. However, it appears that while obesity rates in females may have levelled off in recent years, the rates in males continue to show an upward trend.

Proportion of Population Rated Overweight or Obese
Canada and New Brunswick (2003)



Age-Standardized Obesity Rate
New Brunswick (1995 - 2003)



Body Mass Index

Percentage of adults who report a [computed] body mass index in specified categories, ranging from underweight to obese.

Body Mass Index						
By Gender						
Canada and New Brunswick (2003): Percentage of Population 18+						
Body Mass Index	Canada			New Brunswick		
	Both Genders	Males	Females	Both Genders	Males	Females
Underweight - BMI < 18.5	2.6%	1.2%	4.1%	1.4%	.9% ^E	1.9% ^E
Normal - BMI 18.5 - 24.9	46.7%	41.2%	52.1%	40.3%	35.4%	45.1%
Overweight - BMI 25.0 - 29.9	33.3%	41.0%	25.7%	35.5%	43.0%	28.3%
Obese - BMI > 30.0	14.9%	15.9%	13.9%	20.0%	19.8%	20.1%

Source: Statistics Canada, Canadian Community Health Survey 2003

E: Use with caution

Body mass index (BMI) is based on self-reported height and weight, and calculated for persons 18 years of age and over, excluding pregnant women. Due to different rates of growth for individuals under 18 years of age, the standard BMI is not considered a suitable indicator for this group. BMI is calculated as weight (in kilograms) divided by height (in meters) squared.

Data on height and weight are based on self-report survey responses. Since individuals may not always report reliably, it is widely accepted that BMI measures based on self-reported height and weight may underestimate the prevalence of overweight and obesity in the population.

Age-Standardized Obesity Rate:					
By Gender					
New Brunswick (1995 - 2003): Percentage of Population 18+					
Gender	New Brunswick				
	1995	1997	1999	2001	2003
Male	14.9%	14.5%	15.8%	18.8%	19.5%
Female	19.6%	21.7%	23.3%	19.8%	19.8%

Source: Statistics Canada, Canadian Community Health Survey, 2000/01 and 2003; National Population Health Survey, 1994/95, 1996/97, and 1998/99.

The definition for BMI has been modified from the one used with previous data released by Statistics Canada, in order to respect the latest guidelines from Health Canada, which in turn, correspond to those of the World Health Organisation.

Age-standardization allows for better comparison between years and gender groups by controlling for the aging of the population and differences in the proportions of older and younger individuals in the gender groups.

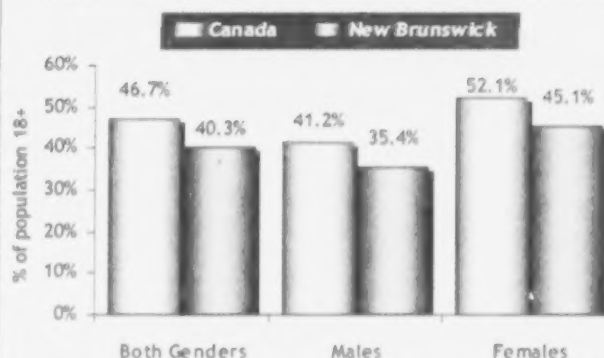
Persons living on First Nation Reserves and on Crown lands, residents of institutions, full-time members of Canadian Armed Forces and residents of certain remote regions are excluded from the calculation of these indicators. Also excluded are pregnant women, and persons measuring less than 91.4 centimetres (3 feet) or greater than 210.8 centimetres (6 feet 11 inches) in height.

Health and Wellness

Body Mass Index

Obesity has been identified as a major risk factor contributing to a number of chronic illnesses such as diabetes and heart disease. Body Mass Index (BMI) is the most common method of determining if an individual's weight is in a healthy range. The effect of excess weight as a risk factor for various diseases increases with BMI above the threshold of 25; this is a widely used standard in the health literature.

Proportion of Population with 'Normal' Body Weight (2003)



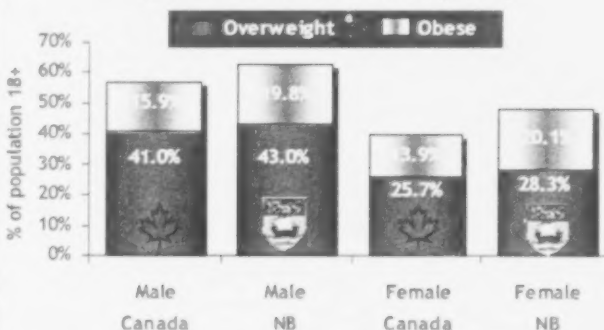
This indicator reports on the percentage of CCHS respondents over the age of 18, excluding pregnant women, with a computed BMI in various categories. BMI calculations are based on the self-reported height and weight of survey respondents.

In 2003, the percentage of males and females with a BMI in the 'normal' range was significantly lower in New Brunswick, than in Canada overall. Additionally, in both New Brunswick and Canada, the percentage of males with a normal BMI was significantly lower than the percentage of females with a normal BMI.

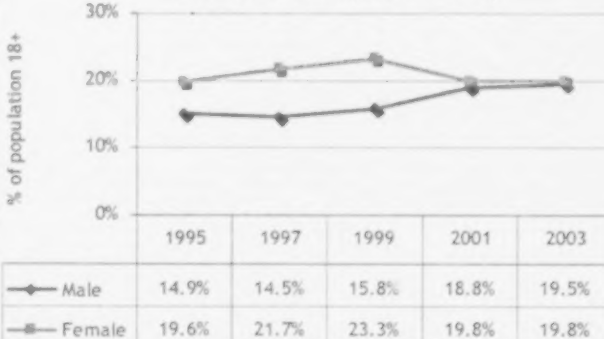
In 2003, the percentage of New Brunswick males and females categorized as overweight was only about two percentage points higher than the corresponding Canadian averages. However, NB men and women were significantly more likely, than Canadian men and women on average, to be categorized as obese.

Year to year changes in obesity rates must be interpreted with caution because changes in survey methods have been found to influence rate estimates. However, it appears that while obesity rates in females may have levelled off in recent years, the rates in males continue to show an upward trend.

Proportion of Population Rated Overweight or Obese
Canada and New Brunswick (2003)



Age-Standardized Obesity Rate
New Brunswick (1995 - 2003)



Body Mass Index

Percentage of adults who report a [computed] body mass index in specified categories, ranging from underweight to obese.

Body Mass Index						
By Gender						
Canada and New Brunswick (2003): Percentage of Population 18+						
Body Mass Index	Canada			New Brunswick		
	Both Genders	Males	Females	Both Genders	Males	Females
Underweight - BMI < 18.5	2.6%	1.2%	4.1%	1.4%	.9% ^E	1.9% ^E
Normal - BMI 18.5 - 24.9	46.7%	41.2%	52.1%	40.3%	35.4%	45.1%
Overweight - BMI 25.0 - 29.9	33.3%	41.0%	25.7%	35.5%	43.0%	28.3%
Obese - BMI > 30.0	14.9%	15.9%	13.9%	20.0%	19.8%	20.1%

Source: Statistics Canada, Canadian Community Health Survey 2003

E: Use with caution

Body mass index (BMI) is based on self-reported height and weight, and calculated for persons 18 years of age and over, excluding pregnant women. Due to different rates of growth for individuals under 18 years of age, the standard BMI is not considered a suitable indicator for this group. BMI is calculated as weight (in kilograms) divided by height (in meters) squared.

Data on height and weight are based on self-report survey responses. Since individuals may not always report reliably, it is widely accepted that BMI measures based on self-reported height and weight may underestimate the prevalence of overweight and obesity in the population.

Age-Standardized Obesity Rate:

By Gender

New Brunswick (1995 - 2003): Percentage of Population 18+

Gender	New Brunswick				
	1995	1997	1999	2001	2003
Male	14.9%	14.5%	15.8%	18.8%	19.5%
Female	19.6%	21.7%	23.3%	19.8%	19.8%

Source: Statistics Canada, Canadian Community Health Survey, 2000/01 and 2003; National Population Health Survey, 1994/95, 1996/97, and 1998/99.

The definition for BMI has been modified from the one used with previous data released by Statistics Canada, in order to respect the latest guidelines from Health Canada, which in turn, correspond to those of the World Health Organisation.

Age-standardization allows for better comparison between years and gender groups by controlling for the aging of the population and differences in the proportions of older and younger individuals in the gender groups.

Persons living on First Nation Reserves and on Crown lands, residents of institutions, full-time members of Canadian Armed Forces and residents of certain remote regions are excluded from the calculation of these indicators. Also excluded are pregnant women, and persons measuring less than 91.4 centimetres (3 feet) or greater than 210.8 centimetres (6 feet 11 inches) in height.

Complete List of 70 Comparable Health Indicators

Primary Health Care (PC)

- 1-PC Difficulty obtaining routine or on-going health services (Feature)
- 2-PC Difficulty obtaining health information or advice (Feature)
- 3-PC Difficulty obtaining immediate care (Feature)
- 4-PC Proportion of population that reports having a regular family doctor
- 5-PC Patient satisfaction with overall health care services (Feature)
- 6-PC Patient perceived quality of overall health care services
- 7-PC Patient satisfaction with community-based care (Feature)
- 8-PC Patient perceived quality of community-based care
- 9-PC Patient satisfaction with telephone health line or tele-health services (Feature)
- 10-PC Patient perceived quality of telephone health line or tele-health services
- 11-PC Proportion of the population reporting contact with a telephone health line or tele-health service
- 12-PC Hospitalization rate for ambulatory care sensitive conditions (Feature)
- 13-PC Proportion of female population aged 18 - 69 with at least one Pap smear test in the past three years
- 14-PC Proportion of women aged 50 - 69 obtaining mammography in the past two years

Home Care (HC)

- 15-HC Home care clients per 100,000 population, all ages
- 16-HC Home care clients per 100,000 population, aged 75 plus

Other Programs & Services (OI)

- 17-OI Wait times for cardiac bypass surgery
 - 17a-OI Median wait time for cardiac bypass surgery
 - 17b-OI Distribution of wait times for cardiac bypass surgery
- 18-OI Wait times for hip replacement surgery
 - 18a-OI Median wait time for hip replacement surgery
 - 18b-OI Distribution of wait times for hip replacement surgery

- 19-OI Wait times for knee replacement surgery
- 19a-OI Median wait time for knee replacement surgery
- 19b-OI Distribution of wait times for knee replacement surgery
- 20-OI Self-reported wait times for surgery
- 20a-OI Median wait time for surgery
- 20b-OI Distribution of wait times for surgery
- 21-OI Self-reported wait times for specialist physician visits
- 21a-OI Median wait time for specialist physician visits
- 21b-OI Distribution of wait times for specialist physician visits
- 22-OI Re-admission rate for acute myocardial infarction (AMI)
- 23-OI Re-admission rate for pneumonia
- 24-OI 30-day in-hospital acute myocardial infarction (AMI) mortality rate
- 25-OI 30-day in-hospital stroke mortality rate
- 26-OI 365-day survival rate for acute myocardial infarction (AMI)
- 27-OI 180-day survival rate for stroke
- 28-OI Patient satisfaction with hospital care (Feature)
- 29-OI Patient perceived quality of hospital care

Catastrophic Drug Coverage & Pharmaceutical Management (DR)

- 30-DR Prescription drug spending as a percentage of income (Feature)

Diagnostic & Medical Equipment (DM)

- 31-DM Wait times for radiation therapy for prostate cancer
- 31a-DM Median wait time for radiation therapy for prostate cancer
- 31b-DM Distribution of wait times for radiation therapy for prostate cancer
- 32-DM Wait times for radiation therapy for breast cancer
- 32a-DM Median wait time for radiation therapy for breast cancer
- 32b-DM Distribution of wait times for radiation therapy for breast cancer
- 33-DM Self-reported wait times for diagnostic services (Feature)

Appendix A

33a-DM Median wait time for diagnostic services

33b-DM Distribution of wait times for diagnostic services

Health Human Resources (HR)

34-HR Patient satisfaction with physician care (Feature)

35-HR Patient perceived quality of physician care

Healthy Canadians (HLT)

36-HLT Life expectancy

36a-HLT Life expectancy for overall population

36b-HLT Life expectancy by income

37-HLT Health adjusted life expectancy (HALE) (Feature)

37a-HLT Health adjusted life expectancy (HALE) for overall population

37b-HLT Health adjusted life expectancy (HALE) by income

38-HLT Infant mortality

39-HLT Low birth weight

40-HLT Mortality rate for lung cancer

41-HLT Mortality rate for prostate cancer

42-HLT Mortality rate for breast cancer

43-HLT Mortality rate for colorectal cancer

44-HLT Mortality rate for acute myocardial infarction (AMI)

45-HLT Mortality rate for stroke

46-HLT Five-year relative survival rate for lung cancer

47-HLT Five-year relative survival rate for prostate cancer

48-HLT Five-year relative survival rate for breast cancer

49-HLT Five-year relative survival rate for colorectal cancer

50-HLT Incidence rate for lung cancer

51-HLT Incidence rate for prostate cancer

52-HLT	Incidence rate for breast cancer
53-HLT	Incidence rate for colorectal cancer
54-HLT	Potential years of life lost due to suicide
55-HLT	Potential years of life lost due to unintentional injury
56-HLT	Incidence rate for invasive meningococcal disease
57-HLT	Incidence rate for measles
58-HLT	Incidence rate for haemophilus influenza b(invasive)(Hib) disease
59-HLT	Incidence rate for tuberculosis
60-HLT	Incidence rate for Verotoxigenic E. Coli
61-HLT	Incidence rate for chlamydia
62-HLT	Rate of newly reported HIV cases
63-HLT	Prevalence of diabetes (Feature)
64-HLT	Exposure to second-hand tobacco smoke rate
65-HLT	Self-reported health (Feature)
66-HLT	Teenage smoking rates (Feature)
66a-HLT	Teenage smoking rates: proportion current teenage smokers
66b-HLT	Teenage smoking rates: proportion daily smokers
67-HLT	Physical activity (Feature)
68-HLT	Body mass index (Feature)
69-HLT	Immunization for influenza, aged 65 plus ("Flu Shot") (Feature)
70-HLT	Prevalence of depression

